Chronic Pain Management Referral Form

Use this form to request a patient's participation in the Utah Medicaid Chronic Pain Program. Include the following in your request.

- ✓ **This form**
- ✓ **History and physical**
- ✓ **Any other pertinent information**

Patient Information

Patient Name: _____

Patient Address _____
_____

City, State, Zip _____

Date of Birth _____

Medicaid ID# _____

Male [ ] Female [ ]

Referring Physician

Name _____

Provider Address_____
_____

City, State, Zip _____

Phone _____

Fax _____

Diagnoses

1.
2.
3.
4.
5.

Office Use Only

Authorization _____
Authorization# if required_____
Secondary Insurance_____
Medical Plan: [ ] FFS [ ] Molina [ ] Healthy U [ ] IHC

Reason for Referral - *mark all that apply*

☐ Pain is chronic, 6 months or more duration.
☐ Concerned by narcotic co-prescribers.
☐ Desire for narcotic analgesia appears out of proportion to presenting symptoms and exam.
☐ Frequent visits for various subjective complaints; resulting in increased narcotic(s) utilization.
☐ Frequent lost, stolen or destroyed prescriptions.
☐ Frequent request for early refills.
☐ I need consultation that I am prescribing the appropriate medications.
☐ Other:_____
_____

Previous Treatment, Medications and Outcome

Mark patient compliance and efficacy

	Efficacy Rating			
	None	Min	Avg	High
Treatments _____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
Medications _____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
Mental Health: _____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]

Assessment:

1. Patient is medically stable. [ ] Yes [ ] No
   How does the patient rate their pain on a scale of 0-10 (10 is highest)?_____

   Indicate any **pending** medical evaluations.

	Name of Provider
[ ] Neurology	_____
[ ] Orthopedic surgery	_____
[ ] Pulmonary	_____
[ ] Ear, Nose, Throat	_____
[ ] Infectious Disease	_____
[ ] Oncology	_____
[ ] Nephrology	_____
[ ] Other	_____

   Indicate any medical evaluations completed in the past 12 months:

[ ] Neurology	_____
[ ] Orthopedic surgery	_____
[ ] Pulmonary	_____
[ ] Ear, Nose, Throat	_____
[ ] Infectious Disease	_____
[ ] Oncology	_____
[ ] Nephrology	_____
[ ] Other	_____

Brief History:_____

_____
_____
_____

Surgeries:(past or pending)_____
_____
_____
_____

Laboratory/Radiology Results_____
_____
_____
_____

Pain is result of:
[ ] herpes
[ ] reflex sympathetic dystrophy
[ ] acute back pain

2. Patient is mentally stable. [ ] Yes [ ] No
If no, list any pending mental health evaluations and mental health provider.

Mental Health Provider_____ Mental Health phone # _____
If diagnosis is available, please list: _____

Does/should this patient receive substance abuse or addiction treatment? [ ] Yes [ ] No

Is this patient in a Methadone treatment program? [ ] Yes [ ] No

Brief Mental History:_____
_____
_____
_____

3. Did you initiate opioid therapy? [ ] Yes [ ] No

4. Does this patient have pain which is significantly reduced by opioids? [ ] Yes [ ] No

5. If the pain is neuropathic in origin, has the patient had adequate trials of drugs for neuropathic pain at the adequate dosage levels such as?
[ ] Neurontin: Dosage_____
[ ] Gabital: Dosage_____
[ ] Topamax: Dosage_____
[ ] other neuropathic medication and dosage:_____

6. Have increased dosage(s) of pain medication resulted in long term improvement in pain and/or function?
[ ] Yes [ ] No
If Yes, describe the improvement and length of time of the improvement?_____
_____

7. Have alternatives to medications for pain relief been tried? [ ] Yes [ ] No

[ ] relaxation
[ ] physical therapy
[ ] occupational therapy
[ ] hypnosis
[ ] meditation
[ ] biofeedback
[ ] acupuncture
[ ] other: _____

8. This person:

[ ] has sleep problems
[ ] has been evaluated for sleep problems

[ ] is taking sleep medications
[ ] does not have a sleep problem

Comments: _____
_____

9. This person has a history of :

[ ] lost medications
[ ] overuse of opioids
[ ] stolen medications
[ ] chronic aggressive or violent behavior
[ ] requesting early refills
[ ] getting medications from multiple providers
[ ] diverting medications
[ ] overdose/suicide attempt

10. This patient has history of:

[ ] nicotine use: packs per day_____
[ ] alcohol use: [ ] daily [ ] 1-2 days/wk [ ] 1-2 days/mon [ ] less than 1-2 days/mon
Type:_____Amount:_____
[ ] psychotropic prescription drugs: _____
[ ] illegal drugs: [ ] marijuana [ ] cocaine [ ] heroin [ ] other narcotics
Type:_____
Amount:_____
[ ] long standing behavioral problems
[ ] use of herbal medications
[ ] numerous attempts at treatment
[ ] dizziness, blackouts, disorientation
[ ] falls, bruises, burns, poor hygiene
[ ] seizures, memory loss, incontinence
[ ] anxiety, headaches, depression, functional decline
[ ] pain interferes with client's ability to remain functional and independent

11. This person has recently experienced:

[ ] death of spouse, parent or child
[ ] physical impairment or disability
[ ] diminished social/family support
[ ] social isolation
[ ] financial problems
[ ] retirement
[ ] divorce
[ ] other _____

Comments _____

_____

_____

PHYSICIAN/ PROVIDER CERTIFICATION

Approval for the Chronic Pain Program requires involvement of the Primary Care Provider (PCP).

I agree to serve as the primary care provider. I agree to coordinate the treatment plan with the Pain Center and will resume prescribing responsibility at the end of the evaluation.

PCP Name _____ **PCP Phone** _____